December 8, 2014
Office of Health Policy
c/o Diona Mullins, Policy Advisor
Cabinet for Health & Family Services
275 E. Main Street, 4W-E
Frankfort, KY 40621

Dear Ms. Mullins:

We would like to respectfully submit comments related to the Certificate of Need Modernization request for stakeholder input. As a major healthcare employer headquartered in the Commonwealth with 28 locations serving – counties and employing approximately 5,500 stakeholders with an economic payroll impact of $132 million and a mission and vision that desires to transform the aging care delivery system, we are honored to be submitting some global thoughts and input related to modernizing state and local healthcare.

There is no question we moved here to be part of the collaborative discussions to overhaul some of the most antiquated healthcare policies in the U.S. In some ways, Kentucky has been a pioneer with introducing case mix reimbursement ahead of 42 others, protecting Medicaid dollars from harsh Managed Care Organizations (MCO's), and expanding our Medicaid enrollees at a time it was negatively impacting family stability.

Being a Kentuckian for nearly 75% of my life, we have maintained the most stringent CON policy in the U.S. because of strong industry lobbying efforts, constraints of healthcare inflation that we could not afford as a state, and fear of uncertainty and change by many healthcare leaders.

Our conservative roots and ideology is something we are proud of because we hate fads, unproven innovation, or fly-by-night organizations that are not part of the Kentucky fabric. Here is what we recommend based upon three points of view –

1. Accessibility for all – much research highlights that strict CON policy can reduce access because the licensed operator has no major incentives to serve less profitable or reduced volume service areas because it reduces their net margin.

2. Innovation and Competition – Due to the strict law, Kentucky has some of the oldest and most antiquated physical plants that are pushing many of our healthcare facilities to near obsolescence just based upon life safety code standards. I believe it has showcased us as tired and draconian, and creates a deferred maintenance liability that may even exceed new construction costs which makes our chance for service interruption or closure more likely in a revenue-contracting time period.

3. Costs to Beneficiary – with so few options, we cannot drive down costs per beneficiary as fast as we need to in order to meet the expanding Medicaid enrollees that will plague us after the federal subsidization is reduced and phased out by 2018. The key to affordability is that we integrate lower cost options into consumer options while keeping enough restriction to maintain provider stability.

Due to these three key initiatives, we recommend the following CON changes or modifications –

A. In our Kentucky Health Plan, the model and calculations are not accurate based upon any demand analysis today due to life expectancy, demographic shifts, and other state utilization based upon having adequate options. The calculations should be modernized based upon more reliable healthcare statistics that are usually in various other states that balance stability with unmet need. This should include predictive modeling to consider other service integration such as out-patient services, non-medical home services, medical home integration, and revised acute care assumptions.

   This would improve access, innovation, and lower costs.

B. In recent periods, the state has enacted "sunshine periods" to move access and capacity between counties and common ownership to better reflect healthcare consumption and need. Many states (recently Florida) believe the current license who has made significant state investment should have first opportunity to meet "demand analysis" (updated in point a.) by using their common ownership, operating structures, etc. to move beds anywhere in uncovered or underserved areas in an organized way that brings millions in physical upgrades to the state (while creating thousands of jobs).

   a. For example, 10% additional beds awarded where providers are already at over 95% occupied on a bi-annual basis so additional beds will spur other physical plant additions like eliminating ward rooms, expanding therapy gym space, adding OP therapy to campuses, and I believe the extra 10% rule linked to high utilized campuses will drive costs down per beneficiary, help providers secure lender support to fund the material community investment, and offer communities and providers better asset quality to make all three vested parties satisfied in an organized manner.

   b. For example, 10% or up to 25 beds, can be moved to another county when the Kentucky Health Plan updated calculations validate the bed capacity should be expanded and there is no other operator in the county service area. This is critical because we cannot have larger organizations or smaller faith-based operators negatively impacted. Where there is no other service line, but providers in another county and common ownership exists, we will see new additions added to facility

campuses, common area space increased in tired locations because the 25 beds can generate enough revenue for the operator to secure the multi-million dollars of capital needed to make such a large investment without injuring small non-profit operators.

c. For example, if operator has a smaller facility that is under 60 beds or less with life safety and code waiver violations they could build a replacement facility in the same service area and add 50% capacity if it did not impede on another operator or was the only operator in the county and the health plan updated calculation validated the need.

Other best practices we have seen in other states that we can learn from are:

A. Provide a new license to existing post-acute providers to add non-medical service lines (home maker, respite, handicap access, life coach, etc.) based upon the need to integrate Medicaid Waivers into our rural marketplace to support the Medicaid expansion in the state. This would provide low cost alternatives to families, reduce nursing home utilization so the "silver tsunami" could be met with reasonable cost assumptions that showcase that the Medicaid expansion is affordable and the state did not make any mistakes.

1. In Tennessee, for example, we have experience related to the state's change in the Physician Assessment Evaluation criteria which has resulted in stricter criteria for nursing home placement for Medicaid recipients, a savings to the state. We have been able to assist with the transition of nursing home residents to their homes through our non-medical services program which provides companion services, light housekeeping, shopping medication reminders and meals. Our non-medical home service product Silver Angels currently has more than 750 customers and employs an army of almost 600 across the state of Tennessee. This has enabled certain former nursing home residents to return to their homes safely, while receiving necessary services at a lower cost through a Medicaid waiver program. We believe that a similar program would be beneficial in Kentucky and should be able to be provided without the necessity of being a Medicare home health provider.

B. The state lets non-profit CCRCs secure a free home health license to the campus in an effort to support "aging in place". This may be a great competitive advantage for larger projects in highly dense urban areas but this concept could be included in limited service areas to existing post acute or skilled operators in a way that would increase home health options in underserved areas based upon the above health plan calculations protecting the current HHA licensee but giving the skilled or post acute

operator the right to "follow the patient" in strict territories which meets episodic care standards giving us a chance to reduce operator costs in a more closed system.

C. With the state funding personal care (PC) as part of the health plan for decades, the commonwealth has funded low acuity care as a resident model linked to a SNF license early on before many other states understood how assisted living would explode. We think we need to consider the Personal Care funding being converted or offer equally as a cost effective ALF waiver option to give consumer greater flexibility. The skilled operators have reduced PC capacity through the years because it was unprofitable for many, others were trying to attract premium pay residents or eliminate ward rooms as a consumer upgrade. We have seen this work in an organized manner in states like Ohio and Florida.

D. Consider securing IGT funding to save sustainable hospitals, reduce the critical access exposure and guarantee collaboration between acute and post acute providers for integrated care despite tougher statewide healthcare demographics to overcome.
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E. With the majority of the 141 hospitals being critical access (nearly 50%) and facing potential federal cuts, our commonwealth could see the largest % of closure. But if we modify the health plan structure we could utilize the IGT program to link a post-acute continuum that creates joint operating governance, aligned quality metrics linked to CMS strategy, and bring in much funding to save as many hospitals that are validated by the health plan. Many of our 141 hospitals may not qualify for IGT but the ones that could, would help the commonwealth develop integrated clinical networks that would help guarantee access and maximize federal funding to reward us for expanded Medicaid access.

F. We are currently building out the care continuum through strategic partnerships with major hospital/healthcare systems concentrating on care quality and reducing risk including in-hospital skilled units, formal post acute JV programs, TransitionalCARE programming integration in Kentucky, Tennessee, etc. and bundled payment for care improvement initiatives in Kentucky as well.

G. Lastly, allow for more competition where warranted based on market-based data and trends in the hospice and home health sector by expanding CON availability and/or permit unused beds in critical access hospitals and SNF settings for palliative, hospice and/or behavioral health.

1. Please see our current market based intelligence data which describes the discharge percentages in the Lexington market. The national average for discharges to Home Health is 14.1% while Lexington is 11.7%, lower than the national average. Discharges, therefore, to IRF's are much higher than the

national average in Lexington. Additional home health opportunities could help alleviate this imbalance.

Market Based Strategic Summary by Market

Lexington Market

Dominant Hospitals								
Hospital Name	Market Share	% to Home	% to HHA	% to SNF	% to LTACH	% to Other IP	% to STACH	% to IRF
National		60.9%	14.1%	20.0%	1.1%	0.5%	0.4%	3.2%
Lexington Market		56.2%	11.7%	19.3%	3.3%	0.4%	0.0%	9.0%
Saint Joseph Hospital	36.0%	59.9%	11.0%	21.2%	3.1%	0.0%	0.0%	4.8%
Baptist Health Lexington	23.0%	50.4%	12.8%	19.5%	3.1%	0.0%	0.0%	14.3%
UK Albert B. Chandler Hospital	22.0%	56.1%	12.0%	15.6%	2.8%	1.4%	0.0%	12.1%
Saint Joseph East	8.0%	56.8%	11.3%	22.4%	6.5%	0.0%	0.0%	3.0%

We understand the significant changes coming to the industry as we face them every day and have a commitment to achieve the Triple Aim of better value, better care and population health improvement with a spiritually holistic component to the clinical and therapy care given, educational opportunities for each stakeholder and our residents, and innovative pursuits for an incoming demographic of baby boomers who will demand a different kind of care and moreover, a care continuum with a momentous customer experience impact.

Thank you so much for your time and consideration related to our submission of feedback. Please do not hesitate to contact us for additional information and expansion on any of these concepts. Moreover, we would like to be considered as a member of future working committees that are taking place in 2015 and will bring the appropriate expertise and manpower.

Happy Holidays and best wishes in this critically important endeavor.

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